STATE OF ARIZONA
CRIME VICTIM COMPENSATION PROGRAM

APPLICATION AND ELIGIBILITY REQUIREMENTS FOR CRIME VICTIM COMPENSATION

IF YOU ARE:

- **An innocent victim of a crime which occurred in the State of Arizona and are legally present in the United States at the time of the crime**
- A resident of Arizona who is injured by an act of international terrorism
- A person who was financially dependant upon an innocent person who is killed as the result of a crime
- A member of the family of the victim who witnessed the crime
- A non-family member who witnessed a heinous crime
- A person whose mental health counseling and care or presence during the mental health counseling and care of the victim is required for the successful treatment of the victim

YOU MAY BE AN ELIGIBLE CLAIMANT OF
THE ARIZONA CRIME VICTIM COMPENSATION PROGRAM

ELIGIBILITY REQUIREMENTS:

1. The crime must be reported to appropriate law enforcement authorities within 72 hours after its discovery unless good cause is shown to justify a delay.
2. The application for an award must be submitted to the appropriate operational unit within one year of the discovery of the crime unless good cause is shown to justify a delay.
3. The crime, or act of international terrorism, directly resulted in the physical injury to, extreme mental distress to, or death of, the victim.
4. The victim and/or claimant fully cooperated with law enforcement officials during the investigation and prosecution.
5. Economic loss (medical expenses, mental health expenses, work loss and/or funeral expenses) has not been or will not be paid by other sources.
6. The victim was not an accomplice to and did not commit a crime in connection with the incident.
7. The Rules require the board to reduce or deny claims that involve the victim's contributory misconduct.

Submitting an application for compensation does not guarantee an award. All claims will be thoroughly investigated.

ELIGIBLE EXPENSES NOT COVERED BY INSURANCE OR OTHER SOURCES:

1. Crime related medical or traditional healing expenses.
2. Crime related mental health counseling and care or traditional healing expenses.
3. Funeral expenses for a deceased victim of criminally injurious conduct or an act of international terrorism.
4. Work loss by the victim, parent, or guardian of a minor victim who accompanies a minor victim to medical, mental health, or traditional healing treatment, or support lost to persons who were dependant upon a deceased victim for support.

Property loss, property damage, pain and suffering, attorney fees, medical report fees, copying fees, and police report fees are ***examples of expenses that are not eligible*** *for compensation.*

TYPE OF COMPENSATION APPLYING FOR			
MEDICAL ☐	**MENTAL HEALTH** ☐	**FUNERAL** ☐	**WAGE LOSS** ☐

HOW TO FILE YOUR APPLICATION:

- Please read all instructions for each section before completing this application.
- Provide all information requested.
- Include copies of your crime related medical bills and other crime related expenses.
- Submit your application to the County Attorney's Crime Victim Compensation Office in the county in which the crime took place.
- If you have any questions while completing the application, please call the County Attorney's Crime Victim Compensation Office in the county in which the crime took place.

ADDITIONAL INFORMATION:

- The application process can take up to 60 days to complete.
- If you disagree with the decision made on your application by the board, you have the right to appeal the decision.

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This document available in alternative formats by contacting the Commission Office at (602) 230-0252.

CRIME VICTIM COMPENSATION APPLICATION

STATE OF ARIZONA
ARIZONA CRIMINAL JUSTICE COMMISSION

RETURN TO:

OFFICE USE ONLY
Date Received: _____
Reviewed by: _____
CVC Claim No: _____

SECTION A: VICTIM INFORMATION

Victim Name: Sex: ☐ Male ☐ Female

Address: *(street, city, state, zip)*

Date of Birth: Home Phone: ( ) Work Phone: ( )

Social Security Number: Is Victim deceased? ☐ Yes ☐ No

Is/was the victim legally present in the United States? ☐ Yes ☐ No

Is the victim a ward of the court? ☐ Yes ☐ No If **Yes**, list name and address of court:

SECTION B: CLAIMANT (APPLICANT) INFORMATION (*If different from victim*)

Claimant Name: Sex: ☐ Male ☐ Female

Address: *(street, city, state, zip)*

Date of Birth: Home Phone: ( ) Work Phone: ( )

Social Security Number:

What is your relationship to the victim or connection with the incident?

Are you claiming benefits for yourself? ☐ Yes ☐ No

Are you legally present in the United States? ☐ Yes ☐ No

Are you claiming benefits on behalf of a dependant of the victim? ☐ Yes ☐ No

If **Yes**, is the dependant legally present in the United States? ☐ Yes ☐ No

If **Yes**, list the following information for each dependant. (*Attach additional sheets if necessary*)

NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP TO VICTIM

(Attach copies of documents to show dependency on the victim)

Is any dependant a ward of the court: ☐ Yes ☐ No
If **Yes**, list name and address of court:

SECTION C: CRIME INFORMATION

Type of Crime (*check one*):

- ☐ Assault/Non-Familial
- ☐ Homicide
- ☐ Sexual Assault/Adults Only
- ☐ Child Physical/ Sexual Abuse
- ☐ Kidnaping
- ☐ Terrorism
- ☐ Domestic Assault/Spouse Abuse
- ☐ DWI/DUI
- ☐ Other Vehicular Crimes
- ☐ Robbery
- ☐ Stalking
- ☐ Arson
- ☐ Other Violent Crime (*please specify*)
- ☐ Other Crime (*please specify*) _____

Date of Crime:	Date Crime Reported:	Agency Reported To:
Name of Officer/Detective:		Report Number:
Location of Crime:		Offender(s) Name:

Has an arrest been made? ☐ Yes ☐ No ☐ Unknown

Was the crime reported to law enforcement within 72 hours of its discovery? ☐ Yes ☐ No ☐ Unknown

If **No**, attach a letter explaining why it was not reported within 72 hours.

Is application being filed within one year of the discovery of the crime? ☐ Yes ☐ No ☐ Unknown

If **No**, attach a letter explaining why it was not filed within one year of discovery of the crime.

SECTION D: BENEFIT INFORMATION

Have you sued the person who committed the crime? ☐ Yes ☐ No ☐ Unknown

If **Yes**, list the name, address and phone number of your attorney.

If **No**, do you intend to sue? ☐ Yes ☐ No ☐ Undecided

Since the crime have you received or are you entitled to receive any of the following benefits:

AHCCCS	☐ Yes ☐ No ☐ Pending	Medicaid	☐ Yes ☐ No ☐ Pending
Auto Insurance	☐ Yes ☐ No ☐ Pending	Offender (Restitution)	☐ Yes ☐ No ☐ Pending
Tricare/military	☐ Yes ☐ No ☐ Pending	Public Assistance/Welfare	☐ Yes ☐ No ☐ Pending
Child Protective Service	☐ Yes ☐ No ☐ Pending	Sick Leave	☐ Yes ☐ No ☐ Pending
Dental Insurance	☐ Yes ☐ No ☐ Pending	Social Security (SSA)	☐ Yes ☐ No ☐ Pending
Disability Insurance	☐ Yes ☐ No ☐ Pending	Social Security (SSI)	☐ Yes ☐ No ☐ Pending
Emergency Assistance	☐ Yes ☐ No ☐ Pending	Tribal Assistance	☐ Yes ☐ No ☐ Pending
Employee Assistance	☐ Yes ☐ No ☐ Pending	Vacation Leave	☐ Yes ☐ No ☐ Pending
General Assistance	☐ Yes ☐ No ☐ Pending	Veteran's Benefits	☐ Yes ☐ No ☐ Pending
Health/Accident Insurance	☐ Yes ☐ No ☐ Pending	Vision Insurance	☐ Yes ☐ No ☐ Pending
Indian Health Services	☐ Yes ☐ No ☐ Pending	Workers Compensation	☐ Yes ☐ No ☐ Pending
Life Insurance	☐ Yes ☐ No ☐ Pending	None	☐ Yes
Medical Insurance	☐ Yes ☐ No ☐ Pending	Other	☐ Yes ☐ No ☐ Pending
Medicare	☐ Yes ☐ No ☐ Pending	(Explain)	

_____

For any of the above resources checked, list the information requested below: (*Attach additional sheets if necessary*)

NAME OF RESOURCE/BENEFIT	ADDRESS	PHONE	AGENCY/ POLICY NUMBER	ELIGIBLE AMOUNT
				$
				$
				$

SECTION E: STATISTICAL INFORMATION (OPTIONAL)

The following information is used for statistical purposes only. It is needed to comply with Federal Regulations. Information applies **only** to the **VICTIM.**

Ethnic Group: ☐ White ☐ Black ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Other

Arizona Resident: ☐ Yes ☐ No **Federal Crime:** ☐ Yes ☐ No
U.S. Citizen: ☐ Yes ☐ No **Handicapped:** ☐ Yes ☐ No

I learned about the Crime Victim Compensation Program from:
☐ Victim Assistance Programs ☐ Medical Service Provider ☐ Law Enforcement Agency ☐ Prosecuting Agency
☐ Social Service Agency ☐ Counseling Facility ☐ News Media/Brochure/Posters ☐ Self referral

SECTION F: CLAIM INFORMATION

1. MEDICAL:

Are you seeking payment for medical, hospital, or traditional healing expenses that are crime related? ☐ Yes ☐ No

If **Yes**, describe the injuries: *(Attach additional sheets if necessary)*

Provide the information requested below for medical services providers. *(Attach additional sheets if necessary)*

NAME OF PROVIDER	ADDRESS	PHONE	DATE OF INITIAL TREATMENT	AMOUNT
				$
				$
				$
				$
				$

Are you claiming travel expenses for crime related medical treatment? ☐ Yes ☐ No

If **Yes**, provide the following information: Date(s) traveled: _____

Number of trips: _____ Miles traveled round trip: _____

2. MENTAL HEALTH COUNSELING:

Are you seeking payment for mental health counseling expenses from crime related stress/emotional problems? ☐ Yes ☐ No

If **Yes**, are you currently seeing a provider? ☐ Yes ☐ No If **No**, are you interested in seeking counseling? ☐ Yes ☐ No

Provide the information requested below for mental health/traditional healing providers if you have received or are now receiving treatment for crime related mental health problems: *(Attach additional sheets if necessary)*

NAME OF PROVIDER	ADDRESS	PHONE	DATE OF INITIAL TREATMENT	AMOUNT
				$
				$
				$

Are you claiming travel expenses for crime related mental health treatment? ☐ Yes ☐ No
If Yes, provide the following information: Date(s) traveled: _____
Number of trips: _____ Miles traveled round trip:

_____

SECTION F: CLAIM INFORMATION(*continued*)

3. WORK/SUPPORT LOSS:

ARE YOU:

(a.) an innocent victim of a crime or act of international terrorism? ☐ Yes ☐ No

(b.) a person filing a claim on behalf of an incapacitated victim of a crime or act or international terrorism? ☐ Yes ☐ No

(c.) a person who was dependant upon a deceased victim for financial support? ☐ Yes ☐ No

(d.) a person making a claim on behalf of a person who was dependant upon a deceased victim for financial support? ☐ Yes ☐ No

(e.) the parent or guardian of a minor victim, who has/will accompany a minor victim to and from medical, mental health, or traditional healing treatment? ☐ Yes ☐ No

- If you have answered **No** to all of the above questions, you are **not** an eligible claimant for work/support loss assistance.
- If you have answered **Yes** to **(a.)** thru **(d.)** above, complete the following information on the **victim's** employment.
- If you have answered **Yes** to **(e.)** above, complete the following information on **your** employment.

Employer (*name, address, city , state)* Phone: ( )

Supervisor's Name: Phone: ( )

Date of Employment: Number of Hours Worked Per Day: Number of Days Worked Per Week:

Pay Rate: $ _____ per _____ Did you receive gratuities/tips? ☐ Yes ☐ No If **Yes**, amount per day: $ _____

Date first unable to work: Date returned to work: Total time lost from work due to the crime:

At the time of the crime, how many persons were dependant upon the victim for support?

A signed statement on office letterhead from the employer will be required to verify the above information. **A signed statement on office letterhead from the doctor, or mental health therapist,** stating that the victim was unable to work as a result of crime related injuries, the length of time the victim was unable to work and the date the victim was, or will be, able to return to work will also be required.

Self-employment: If the victim was self-employed at the time of the crime and income loss or support is claimed, provide Federal tax returns and/or wage statements to verify income for a period of at least one year before the crime.

4. FUNERAL EXPENSES:

Are you seeking payment for crime related funeral expenses? ☐ Yes ☐ No

If **Yes**, **attach a copy of funeral bills, receipts and insurance statements** and provide the information requested below:

Provider of funeral services: *(name)* Phone: ( )

Address: *(street, city, state, zip)*

Total amount of bill: Has any payment been made toward funeral expenses? ☐ Yes ☐ No

If **Yes**, provide the following information: *(Attach additional sheets if necessary)*

PERSON/AGENCY MAKING PAYMENT	DATE PAID	AMOUNT PAID
		$
		$

Have you incurred additional costs related to this death? ☐ Yes ☐ No

If **Yes**, identify and list the additional costs: *(Attach additional sheets if necessary)*

Will claimant or dependants receive or are they entitled to receive money for funeral payment or death benefits? ☐ Yes ☐ No

If **Yes**, list the provider of the payment/benefit (i.e. insurance company, donations, etc.) below: *(Attach additional sheets if necessary)*

Carefully read and sign the declarations below. *Your application will not be processed unless this form is completed and signed on each of the three signature lines.*

Declaration

I hereby certify, subject to the penalty of fine or imprisonment, that the information contained in this application for a crime victim compensation award is true and correct to the best of my knowledge.

Certification of Eligibility

I certify that all of the information provided on this form by me and/or others is true and accurate to the best of my knowledge and belief.

I certify that I am not currently serving a sentence of imprisonment in any detention facility, and had not escaped from serving a sentence of imprisonment in any detention facility, home arrest program or work furlough at the time of the criminally injurious conduct.

I certify that I will fully cooperate with all appropriate law enforcement, prosecutorial and criminal justice agencies and provide the information requested understanding that if I do not cooperate any and all benefits may be denied.

_____ _____ _____Date

Please Print Name Signature of Claimant/Applicant

Arizona Criminal Justice Commission
Subrogation Agreement

Agreement made this _____ day of _____ , 19_____ , between the Claimant,
_____ and the State of Arizona by the Arizona Criminal Justice Commission Crime Victim
(Claimant's Name)
Compensation Program of _____ County.

In consideration of monies to be paid to me or paid to others for my benefit in accordance with the Crime Victim Compensation Program Rules as an award through the Crime Victim Compensation Program,
I, _____ , hereby assign, transfer and subrogate to the State of Arizona the first right to the full extent
(Claimant's Name)
of any monies paid as stated above, and also to the _____ County Crime Victim Compensation Program to the extent that the monies advanced were obtained from sources other than the Arizona Criminal Justice Commission, all rights which I may have to receive, or recover any benefits or advantages which I may have against any party who may be liable for claim, loss, damage, or injuries suffered for which an award was made.

_____ _____ _____

Date Please Print Name Signature of Claimant/Applicant

Authorization to Release Confidential Information

I authorize the release of medical, dental and psychotherapy records to the Crime Victim Compensation Program for the purpose of verifying my claim and my eligibility for Crime Victim Compensation. I authorize and request any person or agency having information, including any law enforcement records, which is necessary to the administration of my claim to release that information to the _____ County Crime Victim Compensation Program. This release includes, but is not limited to, private and government physicians and hospitals; local, state and federal law enforcement and prosecutors offices; local, state, and federal court personnel; any employer; any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I agree and certify that no person or agency shall incur any legal liability to me by releasing any information pursuant to this authorization.

I authorize my attorney to provide any information for the purpose of verifying my claim and eligibility for crime victim compensation and to provide information concerning any potential recovery which I may have against any person or entity arising from the criminally injurious conduct. I understand that the records obtained by the _____ County Crime victim Compensation Program may be subject to release in accordance with the Arizona and Federal Law.

_____ _____ _____

Date Please Print Name Signature of Claimant/Applicant

The Crime Victim Compensation Board in each county determines victim compensation awards. Innocent victims of crime may apply for Crime Victim Compensation, for out-of-pocket crime related costs, in the county in which the crime occurred. For further information call your local county Crime Victim Compensation Program listed below:

Apache County Attorney's Office
(520) 337-4364

Cochise County Attorney's Office
(520) 432-9377

Coconino County Attorney's Office
(520) 779-6163

Gila County Attorney's Office
(520) 425-3231

Graham County Attorney's Office
(520) 428-4787

Greenlee County Attorney's Office
(520) 865-4108

La Paz County Attorney's Office
(520) 669-6118

Maricopa County Attorney's Office
(602) 506-4955

Mohave County Attorney's Office
(520) 753-0719

Navajo County Attorney's Office
(520) 524-4026

Pima County Attorney's Office
(520) 740-5525

Pinal County Attorney's Office
(520) 868-6271

Santa Cruz County Attorney's Office
(520) 281-5868

Yavapai County Attorney's Office
(520) 771-3485

Yuma County Attorney's Office
(520) 329-2133